SALIL GUPTA, M.D.
ORTHOPAEDIC SURGEON • HAND AND UPPER EXTREMITY SPECIALIST
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PATIENT INFORMATION

PATIENT'S NAME (Last,First)	DATE OF BIRTH:	AGE:	SEX:	SOCIAL SECURITY NUMBER:

STREET ADDRESS:	APT. #:	CITY AND STATE:	ZIP CODE:	HOME PHONE NUMBER:

PATIENT'S EMPLOYER:	OCCUPATION (Indicate if Student):	HOW LONG EMPLOYED:	BUSINESS / CELL PHONE NUMBER:

IS INJURY RELATED TO AN ACCIDENT:

☐ WORK ☐ AUTO ☐ OTHER: _____

ARE YOU **RIGHT HANDED** OR **LEFT HANDED**
(Please circle one)

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S / FATHER'S NAME:	STREET ADDRESS, CITY, STATE AND ZIP CODE:	HOME PHONE NUMBER:

MOTHER'S / FATHER'S EMPLOYER:	OCCUPATION:	HOW LONG EMPLOYED:	BUSINESS PHONE NUMBER:

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INSURANCE:

POLICY HOLDER:	DATE OF BIRTH:	EMPLOYER:

☐ WORKERS COMPENSATION ☐ NO FAULT INSURANCE

DATE OF ACCIDENT:	LOCATION:

DESCRIPTION:

WCB NUMBER:	CC NUMBER:

CLAIM / FILE NUMBER:	INSURED:

INSURANCE CARRIER:	CONTACT PERSON (Claim Representative) / TELEPHONE/FAX NUMBER:

INSURANCE CARRIER ADDRESS:	CITY, STATE, ZIP CODE:

LAWYER'S NAME:	TELEPHONE NUMBER:

LAWYER'S ADDRESS:	CITY, STATE, ZIP CODE:

I HEREBY AUTHORIZE THE FOLLOWING:

1. DIRECT PAYMENT FROM MY INSURANCE CARRIER(S) TO SALIL GUPTA, M.D.
2. THE RELEASE OF ANY MEDICAL INFORMATION.
3. PHOTOCOPIES OF THIS FORM TO BE VALID AS THE ORIGINAL.

I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE ENTIRE BILL FOR TODAY'S VISIT AND ANY FUTURE MEDICAL OR SURGICAL BILLS.

X_____ _____

PATIENT'S OR GUARDIAN'S SIGNATURE DATE

Patient Name: _____

Surgeries/Hospitalizations (Please list)	Year	Complications

Have you ever had general anesthesia? Yes ___ No ___
Have you ever had any problems with anesthesia? Yes___ No ___

If yes, please describe: _____

Family History

Please list any significant medical history in your immediate family i.e.: arthritis, cancer etc: &member relation:

_____

Social History

Do you exercise? __ Daily __ Weekly __ Monthly __ Rarely __ Never

If yes, what type of exercise? _____

Any history of substance abuse? __ Yes __ No __ If yes, to what? _____

Do you Smoke currently? __Yes __ No ___ Packs per day ____ # of years

Quit Smoking? __ This year __ >1yr __ >5 yrs __ >10 yrs

Do you drink Alcohol? __ Daily __ 1-2x/week __ 1-2x/month __ 1-2x/yr

Have you had flu shot with in the past 6 months? Yes or No

Have you had a foot exam in the past 6 months? Yes or No

Have you had pneumonia immunization with in the past year? Yes or No

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

(DR. SALIL GUPTA)

Patient Name: _____ Age_____

As required by law, the office needs to know the following pieces of information. Please Circle the most appropriate response to the background questions:

Race:

Asian	Islander	American Indian
Black/African American	Alaskan Native	Other
Native Hawaiian/Pacific	White	Refuse to answer

Ethinicity:
Latino Non-Latino Refuse to answer

Language:
English Spanish ASL Other_____

Height:_____ Weight: _____

Primary Pharmacy:_____

Address: _____

Phone #:_____

Who referred you to come and see Dr. Gupta? _____ Handedness: R L

Please list address & phone#: _____

Is this Dr. currently treating you? Y / N
If No, what doctors have treated you to date? _____

Chief Complaint

Reason for visit today (brief explanation) _____

_____.

Is this the result of an injury? Y / N: If yes, please explain: _____

Current Medication: Dose Reason for Meds

_____

_____

Any Drug Allergies? (please list): _____

Review of Systems:

Are you currently having or have you had problems with any of the following? (circle all that apply)

Diabetes	Balancing problems	Immune Disease	Polio
Insulin Dependency	Numbness/tingling	(Viral/ Auto)	TB Epilepsy
High Blood Pressure	Black-out/fainting	Cancer	Heart Disease
Bleeding problems	Psychological	Arthritis	

Consent to the Use and Disclosure of Health Information

Name: _____

D/O/B: ___/___/___

I understand that as part of my orthopaedic care under the auspices of **Dr. Salil Gupta** and his affiliate staffs (administrative, billing, phone service etc.) the office generates and maintains original medical records, inclusive of my medical history, examination (s), test results and all pertinent data relating to my care. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication amongst the various healthcare professionals who are involved in my care and treatment
- A source of information for billing purposes/claim submissions
- A source of proof for third-party payers that services billed were actually provided
- A point of reference for routine healthcare operations to monitor quality of care

I understand and consent to the use of my medical/billing information be used in connection with any other providers of service directly/indirectly involved with my care knowing that this will be done with prudence under mandatory parameters.

I understand that there is no expiration on this document as it will be used for the duration of my orthopaedic care.

X_____ Date: _____

(signature of patient or legal guardian)

Financial Policy Statement: University Place Orthopaedics 95 University Place New York, N.Y. 10003

The Doctors and office staff at University Place Orthopaedics know that your insurance coverage is very important to you. You are responsible for knowing the benefits, limitations, deductibles and or restrictions that your policy may stipulate. In order to avoid any misunderstandings, we ask that you confirm your benefits with your insurance carrier. Please understand that the exact determination of benefits occurs at the time your insurance company processes and pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You will also receive notification directly from your insurance carrier concerning the benefits paid from your visit.

We must emphasize that our relationship is with you. While filing of insurance claims is a service that we extend to our patients, it is your responsibility that the charges are paid in full. Any known out-of-pocket expenses including deductibles, co-pays, co-insurance and or non-covered services or supplies are due at the time of service. Any amounts denied for any reason by your insurance carrier not known to us are due at the time of claim processing.

Accounts that are unpaid are considered delinquent. These accounts will be referred to our collection agency and or attorney for collection or to small claims court. You, the patient or responsible party shall be responsible for all costs incurred for collections. These may include collection fees, attorney fees and/or court costs. Payment is expected at the time of treatment for all deductibles, co-pays and co-insurance. I understand and agree that I am financially and legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between myself and the carrier and that University Place Orthopaedics is not responsible for settling disputed claims. University Place Orthopaedics will provide the necessary information regarding my treatment in order to facilitate payment of my claim. I also understand and agree that the responsibility for obtaining referrals/authorizations for in-network treatment is solely mine. I understand that I will be seen as an out-of-network patient if I do not obtain the appropriate referral for treatment. It will then be my responsibility for all unpaid benefits.

In addition, I have been advised that my failure and or denial to provide accurate insurance information prior to, or upon my initial visit will mandate that University Place Orthopaedics will assign you as a self-paying or uninsured cash patient. This classification will cause me to forfeit any in-network benefits that University Place Orthopaedics may accept as a participating provider. I will be reinstated as an insured patient once all documentation and referrals are provided. I also understand that University Place Orthopaedics requires 24 hours of notice for any change or cancellation of scheduled appointments and I may be held financially responsible (not my insurance carrier) for late cancellations and missed appointments.

I understand the University Place Orthopaedics financial policy and responsibility for my account.

X_____ _____/_____/_____

Patient/Responsible Party's Signature Date

Payment Disclaimer:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND OR PRIVATE BENEFITS/PAYMENTS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER FOR ANY SERVICES RENDERED TO ME BY THE PHYSICIAN OR SUPPLIER.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION (ABOUT ME) PERMISSION TO RELEASE SAME TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AS IS REQUIRED TO DETERMINE THESE BENEFITS OR ANY BENEFITS PAYABLE FOR RELATED SERVICES

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL

X_____

Patient Signature Required

Patient has been informed of and has signed a HIPPA privacy agreement. This will now be maintained in the chart for reference.

University Place Orthopaedics, LLP

Dear Patient:

We welcome you to our practice and look forward to the opportunity of being a part of your medical care.

It has been determined that you have a close fracture which requires treatment.

Bone healing is a process which will most often occur naturally; however, fracture treatment ensures the best possible function of the injured part after healing. **Dr.Gupta** will be restoring the fractured pieces of bone to their natural position (if Necessary), and further treat you to ensure that the bone maintains those positions while it heals. This process will most likely require X-rays, immobilization with cast or splints, and or braces.

For your billing information, this fracture treatment will be submitted to your insurance company as what is called a "Close treatment of fracture". This coding is classified, by most insurers, as a surgical procedure. Please do not be alarmed if you notice this label on your insurance explanations.

If you have additional questions regarding your treatment plan, please feel free to ask the office manager.

Thank you for your time and consideration.

I_____ , HAVE READ THE ABOVE AND UNDERSTAND HOW MY FRACTURE CARE WILL BE TREATED AND BILLED TO MY INSURANCE CARRIER.

_____ _____

SIGNATURE DATE